

<i>SERFF Tracking Number:</i>	<i>CSLI-126461279</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Citizens Security Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44620</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H20I Individual Health - Vision</i>	<i>Sub-TOI:</i>	<i>H20I.000 Health - Vision</i>
<i>Product Name:</i>	<i>Individual Vision Policy, et al</i>		
<i>Project Name/Number:</i>	<i>NH Vision/</i>		

Filing at a Glance

Company: Citizens Security Life Insurance Company

Product Name: Individual Vision Policy, et al	SERFF Tr Num: CSLI-126461279	State: Arkansas
TOI: H20I Individual Health - Vision	SERFF Status: Closed-Approved-Closed	State Tr Num: 44620

Sub-TOI: H20I.000 Health - Vision	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Author: Rickie Bolduc	Disposition Date: 01/25/2010
	Date Submitted: 01/19/2010	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: NH Vision	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 02/20/2009
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 01/25/2010	Explanation for Other Group Market Type:
	State Status Changed: 01/25/2010
Deemer Date:	Created By: Rickie Bolduc
Submitted By: Rickie Bolduc	Corresponding Filing Tracking Number:

Filing Description:

Enclosed please find an Individual Vision Insurance Program for your review and approval. This is a new policy form and will not replace any existing forms.

The policy is designed to provide Vision Insurance benefits to individual insureds in a Living Care Facility. Benefits include reimbursement of expenses incurred for Covered Vision Expenses, up to the Schedule Amount, subject to any Benefit Frequency Limits and Co-payments as described in the Policy Schedule of Benefits. There is no limit to the Insured Person's choice of provider. The Policy reimburses the lesser of the provider's actual charge and the Schedule Amount.

SERFF Tracking Number: CSLI-126461279 State: Arkansas
Filing Company: Citizens Security Life Insurance Company State Tracking Number: 44620
Company Tracking Number:
TOI: H201 Individual Health - Vision Sub-TOI: H201.000 Health - Vision
Product Name: Individual Vision Policy, et al
Project Name/Number: NH Vision/

It will be issued at all ages without individual underwriting requirements. It will be distributed to individuals using direct response marketing and through independent agents and brokers.

The application that will be used in conjunction with the Individual Vision Policy is form # AP 01 10 AR, which is being filed concurrently, but under separate SERFF number.

Also, I have enclosed an Outline of Coverage and an Actuarial Memorandum containing the premium rates.

Company and Contact

Filing Contact Information

Rickie Bolduc, Actarial Associate rbolduc@cslico.com
PO Box 436149 502-244-2431 [Phone]
Louisville, KY 40253-6149 502-244-2439 [FAX]

Filing Company Information

Citizens Security Life Insurance Company CoCode: 61921 State of Domicile: Kentucky
12910 Shelbyville Road, Suite 300 Group Code: 1310 Company Type: Life and Accident
and Health
PO Box 436149 Group Name: Citizens Financial State ID Number:
Group
Louisville, KY 40253-6149 FEIN Number: 61-0648389
(502) 244-2420 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: product filing all iinclusive; one fee per L.Byrd; \$50.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Citizens Security Life Insurance Company	\$50.00	01/19/2010	33622966

SERFF Tracking Number:	CSLI-126461279	State:	Arkansas
Filing Company:	Citizens Security Life Insurance Company	State Tracking Number:	44620
Company Tracking Number:			
TOI:	H201 Individual Health - Vision	Sub-TOI:	H201.000 Health - Vision
Product Name:	Individual Vision Policy, et al		
Project Name/Number:	NH Vision/		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/25/2010	01/25/2010

<i>SERFF Tracking Number:</i>	<i>CSLI-126461279</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Citizens Security Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44620</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H20I Individual Health - Vision</i>	<i>Sub-TOI:</i>	<i>H20I.000 Health - Vision</i>
<i>Product Name:</i>	<i>Individual Vision Policy, et al</i>		
<i>Project Name/Number:</i>	<i>NH Vision/</i>		

Disposition

Disposition Date: 01/25/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CSLI-126461279 State: Arkansas

Filing Company: Citizens Security Life Insurance Company State Tracking Number: 44620

Company Tracking Number:

TOI: H20I Individual Health - Vision Sub-TOI: H20I.000 Health - Vision

Product Name: Individual Vision Policy, et al

Project Name/Number: NH Vision/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	COVER LETTER	Approved-Closed	Yes
Form	INDIVIDUAL VISION POLICY	Approved-Closed	Yes
Form	VISION OUTLINE COVERAGE	Approved-Closed	Yes

SERFF Tracking Number: CSLI-126461279 State: Arkansas

Filing Company: Citizens Security Life Insurance Company State Tracking Number: 44620

Company Tracking Number:

TOI: H201 Individual Health - Vision Sub-TOI: H201.000 Health - Vision

Product Name: Individual Vision Policy, et al

Project Name/Number: NH Vision/

Form Schedule

Lead Form Number: PA 02 10 AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/25/2010	PA 02 10 AR	Policy/Cont ract/Fratern al Certificate	INDIVIDUAL VISION POLICY	Initial		42.000	Form PA 02 10 AR.pdf
Approved-Closed 01/25/2010	AG 02 10 AR	Outline of Coverage	VISION OUTLINE COVERAGE	Initial			Form AG 02 10 AR.pdf

Citizens Security Life Insurance Company

12910 Shelbyville Road, Suite 300, Louisville, KY 40243

Toll Free Telephone No: 1-800-843-7752

VISION INSURANCE POLICY

The Named Insured as shown in the Policy Schedule of Benefits will be referred to as "You", "Your" or "Yours". Citizens Security Life Insurance Company will be referred to as "We", "Our" or "Us".

IMPORTANT

This is a vision only policy. It does not pay benefits for loss from any other cause. The policy is a legal contract between You and Us.

CONSIDERATION

This policy is issued in consideration of the statements made in Your application and the payment of the premium shown in the Policy Schedule of Benefits. A copy of Your application is attached and is part of this policy. The following paragraphs set forth the insurance benefits, limitations and exclusions, definitions of terms, and other provisions.

YOUR RIGHT TO EXAMINE THIS POLICY- FREE LOOK

It is important to Us that You are satisfied with this policy and that it meets Your insurance goals. If You are not satisfied, You may return it within 30 days after You receive it. You will receive a full refund of all premiums paid, and Your policy will be void from its effective date. If You return the policy, please send it to Citizens Security Life Insurance Company at 12910 Shelbyville Road, Suite 300, Louisville, KY 40243, and note in writing: "This policy is returned for cancellation and refund of premium."

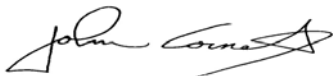
IMPORTANT NOTICE

Please read Your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete to the best of Your knowledge and belief. Carefully check the application. Write to Us within 30 days of the date You receive this policy if any information shown on it is not correct or complete. Incorrect information can result in the denial of a claim or termination of the policy. No duly licensed agent may change this policy or waive any of its provisions.

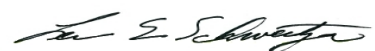
THIS POLICY IS OPTIONALLY RENEWABLE SUBJECT TO OUR RIGHT TO CHANGE PREMIUM RATES ON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without Your consent. We may change the established premium rates effective at renewal dates for Subsequent Policy Years. If the established premium rate changes, We will notify You in writing at Your last known address at least 30 days before the change becomes effective.

READ YOUR POLICY CAREFULLY. The Outline of Coverage provides only a brief description of some of the important features of your policy. The Outline of Coverage is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of You and Us. **IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY.**



President



Secretary

THIS IS A LIMITED POLICY---READ IT CAREFULLY.

VISION INSURANCE POLICY

OPTIONALLY RENEWABLE

PREMIUMS ARE SUBJECT TO CHANGE ON ANY RENEWAL DATE

INDEX

Named Insured.....	Policy Schedule of Benefits: Page 3
Policy Benefits.....	Policy Schedule of Benefits : Page 4
Definitions.....	Part 1: Page 5
Premiums and Renewability.....	Part 2: Page 5
Limitations and Exclusions.....	Part 3: Page 6
Claim Provisions.....	Part 4: Page 6
Miscellaneous Provisions.....	Part 5: Page 7

POLICY SCHEDULE OF BENEFITS

Named Insured: [\[John Doe\]](#)
Mode Of Payment: [\[Monthly\]](#)
Policy Premiums: [\[\\$35.00\]](#)

Policy Number: [\[XXXXXXXXX\]](#)
Policy Effective Date: [\[XX/XX/20XX\]](#)

POLICY SCHEDULE OF BENEFITS

Policy Benefits:

Benefit Frequency Limits:

Exam:	once per 12 months
Frames:	once per 12 months
Standard Lenses (pair):	once per 12 months
Retinal Photograph:	once per 12 months

Copayments:

Exam:	\$0
Materials:	\$0

Schedule Amounts:

Exam:	\$100
Frames:	\$40
Dispensing Fee:	\$25
Single Vision Lenses:	\$40
Bifocal Lenses:	\$60
Trifocal Lenses:	\$80
Lenticular Lenses:	\$80
Retinal Photograph:	\$60

Part 1
DEFINITIONS

- A. OPTICIAN:** a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to provide the vision materials for which a claim is made.
- B. OPTOMETRIST (OD):** a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to provide the vision services for which a claim is made.
- C. OPHTHALMOLOGIST (MD):** a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to provide the vision services for which a claim is made.
- D. COPAYMENT:** the amount that the insured must pay before plan benefits are payable.
- E. IMMEDIATE FAMILY:** anyone related to You in the following manner: spouse; brother or sister (includes stepbrother and stepsister); children (includes stepchildren); parents(s) (includes stepparents); grandchildren; father- or mother-in-law; and spouses as applicable, of any of these.
- F. INSURED:** the Named Insured as shown in the Policy Schedule of Benefits.
- G. POLICY YEAR:**
 - 1. **First Policy Year:** the period of time that begins on the effective date of coverage as shown in the Policy Schedule of Benefits and ends 365 days from the effective date.
 - 2. **Each Subsequent Policy Year:** every 12-month period thereafter.
- H. COVERED VISION EXPENSE:** is the lesser of the actual charge or the Schedule Amount.
- I. SCHEDULE AMOUNT:** the amount shown in the Policy Schedule of Benefits.

Part 2
PREMIUMS AND RENEWABILITY

- A. PREMIUM DUE DATE:** The initial premium is due and payable on the Policy Effective Date, as shown in the Policy Schedule of Benefits. Subsequent premiums are due and payable at the beginning of each renewal term.
- B. CHANGES IN PREMIUM RATES:** We have the right to change the premium rate on the following dates:
 - a. After the policy has been in force for one year, on any renewal date; or
 - b. The effective date of any change in benefits under the policy; or
 - c. On the effective date of any law or regulation that affects Our liability under the policy.

We will give you at least 30 days written notice prior to any change in premium rates.

- C. GRACE PERIOD:** Unless We have delivered to You, or have mailed to Your last address as shown by Our records, at least ninety (90) days prior to the premium due date a written notice of Our intention not to renew this policy beyond the period for which the premium has been accepted, a grace period of 31 days will be granted for the payment of each premium due after the initial premium. The policy shall continue in force during the grace period.
- D. FAILURE TO PAY PREMIUM WHEN DUE:** If a premium is not paid within the Grace Period, this Policy will terminate at the end of the last day for which Premium has been received.
- E. RETURN OF UNEARNED PREMIUM:** Upon cancellation of this policy, We will promptly return to you the unearned portion of any premium paid beyond the month in which the cancellation is effective.

F. RENEWABILITY: We reserve the right to refuse renewal of this policy. Subject to the right to terminate the policy upon nonpayment of premium when due, such right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on each policy anniversary (or in the case of lapse and reinstatement, at the renewal date occurring on each anniversary of the last reinstatement). Any refusal of renewal shall be without prejudice to any claim originating while the policy was in force.

G. TERMINATION: Coverage under this policy will end on the earliest of the following dates:

- a. The last day of the last month for which a required premium is paid;
- b. The premium due date following the expiration of the 90 day notice to You of Our intent to terminate; or
- c. The premium due date following the expiration of Your 90 day notice to Us of Your intent to terminate.

Part 3 **LIMITATIONS AND EXCLUSIONS**

This Policy does not cover losses caused by or resulting from:

1. Any material or service not shown on the Policy Schedule of Benefits.
2. Any material or service that exceeds the Benefit Frequency Limits shown on the Policy Schedule of Benefits.
3. Any material or service We consider being experimental or investigative.
4. Any material or service received before Your effective date.
5. Any material or service received after Your coverage terminates without prejudice to any claim originating prior to the effective date of termination.
6. Charges for any material or service provided by other than a licensed Optician, Optometrist, or Ophthalmologist.
7. Any material or service received while outside the territorial limits of the United States.
8. Any material or service required as a result of disease or injury that is due to war or an act of war (whether declared or undeclared); taking part in an insurrection or riot; the commission or attempted commission of a felony; an intentionally self-inflicted injury or attempted suicide while sane or insane.
9. Any material or service performed by an Optician, Optometrist, or Ophthalmologist who is a member of the Insured Person's Immediate Family.

Part 4 **CLAIM PROVISIONS**

- A. NOTICE OF CLAIM:** Written notice of claim must be given to Us within sixty (60) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of You or the beneficiary to Citizens Security Life Insurance Company, 12910 Shelbyville Road, Suite 300, Louisville, KY 40243, or to any authorized agent of Ours, with information sufficient to identify You, shall be deemed notice to Us. Notice of claim should include the name of the Insured and the policy number.
- B. CLAIM FORMS:** Upon Our receipt of a notice of claim, We will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.
- C. PROOF OF LOSS:** Proof of loss must be furnished to Us in case of claim for loss for which this policy provides payment within ninety (90) days after the termination of the period for which We are liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

- D. TIME OF PAYMENT OF CLAIMS:** Benefits payable under this policy will be paid within thirty (30) days of receipt of due written proof of the loss or within three (3) business days of receipt of due proof of loss for claims submitted electronically.
- E. PAYMENT OF CLAIMS:** All benefits will be payable to You unless assigned by You or by operation of law. Any accrued benefits unpaid at Your death will be paid to Your estate or assignee.
- F. CLAIMS REVIEW PROCEDURE:** If a claim is denied in whole or in part, You or your authorized representative or a provider acting on your behalf, may request a review of the claim. The request must be in writing and must be made within sixty (60) days after the claim was denied. Send the request to Us. The request should contain any facts You consider important to the review. We will review the claims decision and send a response in writing within thirty (30) days. If the denial of benefits is confirmed, You will be told the reasons for the decision.

Part 5

MISCELLANEOUS PROVISIONS

- A. ENTIRE CONTRACT; CHANGES:** This policy, together with the application, endorsements, benefit agreements and attached papers, if any, is the entire contract of insurance. No change in the policy is valid until approved in writing by Our president or secretary. This approval must be noted on or attached hereto. No duly licensed agent may change this policy or waive any of its provisions.
- B. TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.
- C. TERM:** The term of this policy begins at noon, standard time, at the place where You reside on the effective date shown in the Policy Schedule of Benefits. It ends at noon, the same standard time, on the first renewal date. Each renewal term ends at noon, the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of the policy is shown in the Policy Schedule of Benefits. An annual premium will maintain the policy in force for 12 months, semiannual for six months, quarterly for three months and monthly for one month.
- D. REINSTATEMENT:** If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: provided, however, that if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated policy shall cover only loss resulting from accidental injury of a Covered Vision Expense as may be incurred after the date of reinstatement as may begin more than ten (10) days after such date. In all other respects You and We shall have the same rights thereunder as each had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.
- E. LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.
- F. UNPAID PREMIUM:** Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

- G. OTHER INSURANCE WITH THIS INSURER:** Insurance effective at any one time on the insured under this policy and a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.
- H. CONFORMITY WITH STATE AND FEDERAL STATUTES:** Any provision of this policy that on its effective date is in conflict with the statutes of the state in which the insured resides on such date or with any federal statutes is hereby amended to conform to the minimum requirements of such statutes.
- I. PHYSICAL EXAMINATIONS OR AUTOPSY:** We can have the Insured medically examined, at Our expense, while a claim is pending as often as We deem reasonably necessary to determine the validity of claim. We can also have an autopsy performed unless prohibited by law.

VISION INSURANCE POLICY – Form PA 02 10 AR

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY - This outline of coverage provides only a brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Citizens Security Life Insurance Company. **IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY CAREFULLY.**

Vision Expense Coverage ONLY – The policy only provides coverage for vision expenses as listed in the Policy Schedule of Benefits. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses due to sickness.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

POLICY BENEFITS

Benefit Frequency Limits:

Exam:	once per 12 months
Frames:	once per 12 months
Standard Lenses (pair):	once per 12 months
Retinal Photograph:	once per 12 months

Copayments:

Exam:	\$0
Materials:	\$0

Schedule Amounts:

Exam:	\$100
Frames:	\$40
Dispensing Fee:	\$25
Single Vision Lenses:	\$40
Bifocal Lenses:	\$60
Trifocal Lenses:	\$80
Lenticular Lenses:	\$80
Retinal Photograph:	\$60

LIMITATIONS AND EXCLUSIONS

The Policy does not cover losses caused by or resulting from:

1. Any material or service not shown on the Policy Schedule of Benefits.
2. Any material or service that exceeds the Benefit Frequency Limits shown on the Policy Schedule of Benefits.
3. Any material or service We consider being experimental or investigative.
4. Any material or service received before Your effective date.
5. Any material or service received after Your coverage terminates.
6. Charges for any material or service provided by other than a licensed Optician, Optometrist, or Ophthalmologist.
7. Any material or service received while outside the territorial limits of the United States.
8. Any material or service required as a result of disease or injury that is due to war or an act of war (whether declared or undeclared); taking part in an insurrection or riot; the commission or attempted commission of a felony; an intentionally self-inflicted injury or attempted suicide while sane or insane.
9. Any material or service performed by an Optician, Optometrist, or Ophthalmologist who is a member of the Insured Person's Immediate Family.

RENEWABILITY

This policy is optionally renewable subject to our right to decline coverage on any individual and change premium rates upon any renewal date.

We reserve the right to refuse renewal of this policy. Subject to the right to terminate the policy upon nonpayment of premium when due, such right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on each policy anniversary (or in the case of lapse and reinstatement, at the renewal date occurring on each anniversary of the last reinstatement). Any refusal of renewal shall be without prejudice to any claim originating while the policy was in force.

PREMIUMS ARE SUBJECT TO CHANGE ON ANY RENEWAL DATE.

*This **Outline of Coverage** is presented as a matter of general information only and the contents are not to be accepted nor construed as a substitute for the provisions of the policy. This is **not** the insurance contract and only the actual policy provisions will control.*

SERFF Tracking Number:	CSLI-126461279	State:	Arkansas
Filing Company:	Citizens Security Life Insurance Company	State Tracking Number:	44620
Company Tracking Number:			
TOI:	H201 Individual Health - Vision	Sub-TOI:	H201.000 Health - Vision
Product Name:	Individual Vision Policy, et al		
Project Name/Number:	NH Vision/		

Supporting Document Schedules

	Item Status:	Status
		Date:
Satisfied - Item: Flesch Certification	Approved-Closed	01/25/2010
Comments:		
Attachment:		
Readability Cert.pdf		

	Item Status:	Status
		Date:
Satisfied - Item: Application	Approved-Closed	01/25/2010
Comments:		
APPLICATION IS BEING FILED WITH SERFF # CSLI-126461188		
Attachment:		
Form AP 01 10 AR.pdf		

	Item Status:	Status
		Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	01/25/2010
Bypass Reason: OUTLINE IS BEING FILED FOR APPROVAL.		
PLEASE SEE ATTACHED UNDER FORM SCHEDULE.		
Comments:		

	Item Status:	Status
		Date:
Satisfied - Item: COVER LETTER	Approved-Closed	01/25/2010
Comments:		
DETAILS OF THE FILING.		
Attachment:		
Cover Letter.pdf		

Citizens Security Life Insurance Company

**12910 Shelbyville Road, Suite 300
Louisville, KY 40243**

Readability Certification

I, James Helton, Executive Vice President, Citizens Security Life Insurance Company, hereby certify that Form # PA 02 10 AR has a Flesch Scale readability score of 42.

I also certify, to the best of my knowledge and belief, the form is in compliance with the statutes and regulations for simplified and readability policy forms of the state for which it is being filed.

Signed for: Citizens Security Life Insurance Company

Date: January 19, 2010



By:

Title: Executive Vice President

Citizens Security Life Insurance Company

12910 Shelbyville Rd, Ste 300

Louisville, KY 40243

**LIVING CARE FACILITY RESIDENT
APPLICATION FOR INSURANCE****800-843-7752**

APPLICATION TYPE		FOR COMPANY USE ONLY			
<input type="checkbox"/> New Applicant. <input type="checkbox"/> Change.		Billing#.		Acct#.	
		Effective Date.			
COVERAGE REQUESTED	MONTHLY PREMIUM	Dental Plan.			
<input type="checkbox"/> Dental.	\$ _____	Vision Plan.			
<input type="checkbox"/> Vision.	\$ _____	PID.			
APPLICANT INFORMATION					
Last Name.		First Name.		M.I.	
				Social Security #:	
Sex. <input type="checkbox"/> Male. <input type="checkbox"/> Female.		Date of Birth: (mm/dd/yyyy). / /			Medicaid #: (if applicable).
LEGAL REPRESENTATIVE (IF OTHER THAN THE APPLICANT IS SIGNING THIS APPLICATION)					
Last Name.		First Name.		M.I.	
Address.		City.		State.	Zip Code.
Phone #: ()		E-mail.			
FACILITY WHERE APPLICANT RESIDES					
Name.					
Address.					
AUTHORIZATION					
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.					
I understand that coverage will not be effective until this application and the applicable premium has been received and accepted and the policy has been issued by the Company.					
This application or a copy is also my request and authorization for necessary diagnostic and preventive treatment as well as any necessary repair or adjustment of prosthodontics.					
Applicant/Legal Representative Signature.				Date.	
Agent Name/Number.		Agent Signature.		Date.	



January 19, 2010

Arkansas Department of Insurance
Health Division, Forms and Rates
1200 West 3rd Street
Little Rock, AR 72201

Re: Citizens Security Life Insurance Company - **New Submission**
NAIC # 61921 FEIN # 61-0648389
Form Number: PA 02 10 AR; Individual Vision Insurance Policy
AG 02 10 AR; Outline of Coverage
Actuarial Memorandum and Rates

Dear Sir/Madam:

Enclosed please find an Individual Vision Insurance Program for your review and approval. This is a new policy form and will not replace any existing forms.

The policy is designed to provide Vision Insurance benefits to individual insureds in a Living Care Facility. Benefits include reimbursement of expenses incurred for Covered Vision Expenses, up to the Schedule Amount, subject to any Benefit Frequency Limits and Co-payments as described in the Policy Schedule of Benefits. There is no limit to the Insured Person's choice of provider. The Policy reimburses the lesser of the provider's actual charge and the Schedule Amount.

It will be issued at all ages without individual underwriting requirements. It will be distributed to individuals using direct response marketing and through independent agents and brokers.

The application that will be used in conjunction with the Individual Vision Policy is form # AP 01 10 AR, which is being filed concurrently, but under separate SERFF number.

Also, I have enclosed an Outline of Coverage and an Actuarial Memorandum containing the premium rates.

If you should have any questions concerning this filing, please contact me at (800) 843-7752 or e-mail rbolduc@cslico.com. Your prompt attention to this filing is greatly appreciated.

Sincerely,

A handwritten signature in black ink that reads 'Rickie Ellen Bolduc'.

Mrs. Rickie Ellen Bolduc, FLMI, AIRC, ACS
Actuarial Associate
Citizens Security Life Insurance Company